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### Provider Locator

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If you would like to identify a network provider prior to enrolling in or using the Spectera Vision Care Program, visit Spectera's Web site at [www.spectera.com](http://www.spectera.com) and select "Future Member." Then, enter the ZIP code of your choice. If you prefer, call Spectera's Provider Locator Service at 1-800-839-3242 and follow the voice prompts:

- Select language desired.
- Select Option 1 "Open Enrollment" to locate doctors by zip code.
- The system will then identify up to three network providers in the requested ZIP code's area. If you wish to hear the selections again, "Press 1". To enter another five-digit ZIP code, "Press 2".

Prior to using your benefits at a Network Provider, please call the provider and make an appointment. Please inform the provider that you are a Spectera participant.

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### Important Points to Remember

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- Always identify yourself as a Spectera participant when making your appointment. This will assist your provider in obtaining a claim authorization prior to your visit.
- Your \$105 contact lens allowance is applied to the fitting fee and evaluation as well as the purchase of contact lenses (for instance, contacts at WalMart). For example, if the fitting fee and evaluation is \$33, you will have \$72 towards the purchase of contact lenses. The allowance may be separated at some retail locations between the examining physician and the optical store. Some out-of-pocket expense may result from the purchase of contacts not included in the Spectera selection, such as, torics, gas permeable and bifocal contact lenses.

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### Important Points to Remember (continued)

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- Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.
- Benefits for contact lenses are in lieu of a lens and frame. Your provider will help you determine which contact lenses are covered under your benefit. Contacts should be purchased for the year during one visit.
- Benefits available every 12 or 24 months (depending on the benefit frequency) based on last date of service.
- Lens options such as UV coating, progressive lenses, etc., are not covered in full, but are provided to Spectera members at a savings below usual and customary charges.

The following Services and Materials are excluded from coverage under the Policy:

1. Post cataract spectacle lenses;
2. Non-prescription items,
3. Medical or surgical treatment for eye disease, that requires the services of a physician,
4. Worker's Compensation services or materials,
5. Services or materials that the patient, obtains without cost from any governmental organization or program,
6. Services or materials which are not specifically covered by the Policy,
7. Plain sunglasses,
8. Replacement or repair of lenses and/or frames which have been lost or broken,
9. Cosmetic extras, except as stated in the Policy's Table of Benefits.

**Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document.**

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## VISION CARE BENEFITS

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# State of Wisconsin Employees



Spectera Corporate Headquarters  
2811 Lord Baltimore Drive  
Baltimore, Maryland 21244-2644  
Customer Service: 800 / 638-3120  
Provider Locator: 800 / 839-3242  
**[WWW.SPECTERA.COM](http://WWW.SPECTERA.COM)**

*Underwritten by  
UnitedHealthcare Insurance Company*

## Vision Care Disclaimer

This insurance plan has been authorized by the Group Insurance Board (Board) for the purpose of permitting premium collection through payroll deductions under authority granted by Wis. Stat. § 40.03 (6) (b) and pursuant to Wis. Stat. § 20.921 (1) (a) 3. The criteria the Board uses involves meeting several requirements which include, but are not limited to: documentation of financial stability, demonstration of a reasonable ratio of claims paid to the premium level, authority to conduct business in the State of Wisconsin, agreeing to conditions for the rate-making process and other administrative conditions. Employee Trust Funds (ETF) staff and the Board's actuary review proposals for participation prior to Board approval. However, the Board does not require competitive bids nor a benefit comparison with similar products from other vendors. **Authorization for payroll deduction should not be construed as an endorsement of this plan by either the Group Insurance Board or the Department of Employee Trust Funds.** Premiums will be deducted from your paycheck on a pre-tax basis automatically, unless you file an Employee Reimbursement Accounts (ERA) Program Automatic Premium Conversion Waiver form (ET-2340) with your payroll office when you sign up for this benefit. Remember that the copays and other expenses for vision care that are not paid for by this benefit plan may be reimbursed through your ERA Medical Reimbursement Account.

## Vision Benefit Reference Card

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Spectera Vision Program	
Group: State of Wisconsin Employees	
Exam	once every 12 Months
Lenses	once every 12 Months
Frame	once every 24 Months
Contacts*	once every 12 Months
*(in lieu of lenses & frames)	
\$10 Exam Copay	\$25 Material Copay

## Network Benefits

Enrolled participants and eligible dependents are eligible for the following at a network provider.

**Examination:** A comprehensive vision examination, provided by a network optometrist or ophthalmologist, is 100% covered after a \$10 exam copay, once every 12 months.

**Lenses** - If prescribed, standard single vision or standard multi-focal lenses are 100% covered, after a \$25 material copay, once every 12 months.

**Frames** - Your choice of Spectera selection frames is covered in-full, after a \$25 material copay, once every 24 months. If you select frames from outside the Spectera selection, you will have a \$50.00 wholesale frame allowance at our private practice providers or a \$130.00 retail frame allowance at our retail optical providers. **Only one \$25 material copay will apply if the lenses and frames are purchased during the same benefit year.**

**Contact Lenses** - In lieu of lenses and frames, you may select contact lenses. Spectera's covered contact lens benefit includes the fitting/evaluation fees, contact lenses, and up to two follow-up visits. If covered disposable contact lenses are chosen, up to four boxes (depending on prescription) are included when obtained from a network provider. Spectera's covered contact lenses may vary by provider and contacts should be purchased for the year during one visit. Should you choose contact lenses outside of the covered selection, a \$105 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses once every 12 months (materials copay does not apply). Toric, gas permeable, and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts. Necessary contacts covered-in-full after applicable copay.

**Lens Options** - Should you choose lens options not covered by the program such as, but not limited to, progressive lenses, polycarbonate lenses, high index, tints, UV, and anti-reflective coating, you may be able to purchase these options at a discount. Standard scratch coating is covered-in-full.

**Refractive Eye Surgery** - Spectera participants receive access to discounted refractive eye surgery procedures from numerous provider locations throughout the United States. To find a participating laser eye surgeon, visit our web site at <https://www.spectera.com/visionLaser.html>.

## Out-of-Network Benefits

If you elect vision coverage and choose to use a non-Network Provider, you will be reimbursed **up to**:

<b>Exam</b>	
Optometrist	\$40.00
Ophthalmologist	\$40.00
<b>Lenses (Pair)</b>	
Single vision	\$40.00
Bifocal	\$60.00
Trifocal	\$80.00
Lenticular	\$80.00
<b>Frames</b>	\$45.00

### Contact Lenses (in lieu of spectacle lenses and frames)

Medically Necessary**	\$210.00
Elective*	\$105.00

\* Less any network fitting/evaluation fee.  
\*\* Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: following cataract surgery, to correct extreme vision problems that cannot be corrected with spectacle lenses, with certain conditions of anisometropia, and with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact Spectera concerning the reimbursement that Spectera will make before you purchase such contacts.

If you choose a **non-Network Provider**, you will need to send your itemized receipts with the primary-insured's Social Security number and the patient's name and date of birth to:

### Spectera Claims Department

P. O. Box 26618

Baltimore, MD 21207-6618

Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Spectera will reimburse you according to the schedule shown above.

If you have any questions or concerns about your vision options, please contact Spectera's Customer Service Center at:

1-800-638-3120

7:30 a.m. to 7:00 p.m. CT Monday – Friday

8:00 a.m. to 4:00 p.m. CT Saturday

[www.spectera.com](http://www.spectera.com)